

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$5,748.50 for dates of service, 07/18/01 & 09/14/01.
- b. The request was received on 07/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. UB-92(s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Medical Records
 - e. Example EOBs from other Insurance Carriers
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/13/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/13/02. The response from the insurance carrier was received in the Division on 08/26/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of A Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/08/02 – Please note that page 2 of the Requestor's position statement was not found in the dispute file.

“We are appealing the amount disallowed on the above mention [sic] claims. These charges are for **FACILITY FEES**, not professional fees. We feel that 17% & 19% paid on a right carpal tunnel release and a repeat extensive neurolysis of the median nerves of the right wrist is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as \$630.00 for each date of service does not cover our cost to perform these surgeries....(Carrier's) methodology is neither fair nor reasonable and is very difficult to understand it's meaning....this methodology does not take in account for the regional or geographic differences. This reimbursement methodology is neither fair nor reasonable based on what other workers' compensation and group insurance carriers are paying....(Carrier) has unfairly reduced our bill when other worker's compensation carriers' have established that our charges are fair and reasonable....Enclosed are examples of bills for the same type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid.”

2. Respondent: Letter dated 08/26/02

“(Carrier's) payment is consistent with the fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code. (Carrier) used data from two national resources: 1) ASC charges as listed by CPT code in ‘1994 ASC Medicare Payment Rate Survey,’ and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code. (Carrier) used this data in the following manner: 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare's ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine fair and reasonable payment for the service. In this dispute (Carrier) took the CPT code used by the surgeon, 64721, and applied its methodology to determine fair and reasonable payment of \$1,260.00 (630.00 for each date of service)....For these reasons, (Carrier) believes it has made a fair and reasonable payment for the services provided on 7/18/01 and 9/14/01.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 07/18/01 & 09/14/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$7,008.50 for services rendered on 07/18/01 & 09/14/01.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$1,260.00 for services rendered on 07/17/01 & 09/14/01.
5. The Carrier's EOBs denied any additional reimbursement as "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B).
6. Per the Requestor's Table of Disputed Services, the amount in dispute is \$5,748.50 for services rendered on the dates of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted several examples of other Carrier's EOBs for charges billed for a similar procedure. However, the carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
1. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
2. reference its method in the claim file; and
3. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable; and likewise, the requestor's example EOBs do not refute that the Respondent has developed and consistently applied its methodology to determine fair and reasonable.

The Respondent indicates that the following data was used to determine their fair and reasonable reimbursement: 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare's ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine fair and reasonable payment for the service.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. As the requestor, the health care provider has the burden to provide documentation that "...discussed, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement..." pursuant to TWCC Rule 133.307 (3) (g) (D). While the requestor has attached several copies of example EOBs, they have failed to demonstrate how this documentation is utilized in their determination of the amount billed. Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d),

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 11th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt